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Department of Veterans Affairs **VHA DIRECTIVE 2003-039**
Veterans Health Administration
Washington, DC 20420 **July 18, 2003**

UPDATED BILLING GUIDANCE FOR SERVICES PROVIDED BY TEACHING PHYSICIANS AND RESIDENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides guidance for billing insurance carriers for services provided by a health care team, which includes attending physicians and residents and/or fellows (residents). ***NOTE****: The term "fellow" is used by some sponsoring institutions and in some specialties to designate participants in subspecialty graduate medical education (GME) programs. Because the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), treats "fellows" identically to "'residents,"' the term "resident" is used throughout this document. Residents who have the title Chief Resident are considered residents.*

2. BACKGROUND

a. Since the Department of Veterans Affairs (VA) has been submitting claims to third-party insurers for professional fees, there has been a discrepancy between the billing requirements for physician services and the requirements for documenting resident supervision for educational purposes. In order to clarify these differences, an opinion was requested from the Department of Health and Human Services, CMS as to whether VA's residency programs meet Medicare teaching physician supervision requirements and additionally whether VA can submit claims for services provided by residents.

b. CMS has ruled that the attending physician presence and documentation requirements in CMS guidance are to avoid fraud and overpayments in institutions where GME support has been paid by CMS. Since VA hospitals do not receive either direct medical education (DME) or indirect medical education (IME) funds from CMS, it has been determined that VA can submit claims for care that is provided by residents in a properly supervised environment. CMS explicitly stated that the teaching physician billing rules do not apply to physicians in VA. Additionally, CMS has ruled that residents do not need to be enrolled in Medicare in order for a claims submission to occur.

c. VHA Handbook 1400.1, Resident Supervision, is the primary guidance for the documentation of care in teaching settings. This handbook sets out standards for documentation of resident delivered care that is educationally appropriate and maintains the highest standards for high quality and safe patient care and is available on the VA intranet at http://vaww.va.gov/oaa/.

d. There will be no changes in the provision of health care for our veteran patients. A VA staff physician must still supervise and be responsible for all resident delivered care. However, any documentation requirements driven strictly by the CMS billing standards will no longer apply. All documentation practices at VA facilities will be reviewed against the VHA Resident Supervision policy.

3. POLICY: It is VHA policy that claims must be submitted to all insurance carriers for care that is provided by residents in a properly supervised environment.

THIS VHA DIRECTIVE EXPIRES JULY 31, 2008

4. ACTIONS: The facility Director is responsible for ensuring that:

a. Claims are submitted to Medicare supplemental insurance plans or are submitted to plans coordinating benefits with Medicare; in these cases, the claim must record the residents name and credentials. ***NOTE:*** *Medical centers can back bill for resident services as long as the timely filing requirements are met for the individual policy and the services meet the documentation requirements*.

b. VHA staff accurately reflect health care services delivered and identify the person providing the care on a claim by:

(1) Coding the health care services for each patient from the medical record, and identifying the person who provided care.

(2) Validating the documentation of health care services in the patient's medical record.

(3) Instituting procedures to ensure compliance with insurance industry standards, as applicable.

(4) Validating and monitoring the automated encounter form data to facilitate the coding and billing process.

c. All residents and all health care providers are aware of the billing policy.

NOTE: *Refer to Attachment A for additional information regarding this billing Directive.*

5. REFERENCES: VHA Handbook 1400.1.

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Business Office (16) is responsible for the contents of this Directive. Questions should be addressed to 202-254-0362.

7. RESCISSION: VHA Directive 2001-054 is rescinded. This VHA Directive expires July 31, 2008.

S/ Nevin M. Weaver for
Robert H. Roswell, M.D.
Under Secretary for Health

Attachment

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ATTACHMENT A

FREQUENTLY ASKED QUESTIONS REGARDING CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DOCUMENTATION REQUIREMENTS FOR DEPARTMENT OF VETERANS AFFAIRS (VA) TEACHING PHYSICIANS

Question 1: What is the new Centers for Medicare and Medicaid Services (CMS) ruling about documentation requirements for Department of Veterans Affairs (VA) teaching physicians?

Answer: CMS has ruled that the attending physician presence and documentation requirements in CMS guidance are to avoid fraud and overpayments in institutions where Graduate Medical Education support has been paid by CMS. Since VA medical facilities do not receive either direct medical education (DME) or indirect medical education (IME) funds from CMS, it has been determined that VA can submit claims for care that is provided by residents in a properly supervised environment. CMS explicitly stated that the teaching physician billing rules do not apply to physicians in VA. Additionally, CMS ruled that residents do not need to be enrolled in Medicare for claims submission to occur.

Question 2: Does this mean that residents won't be supervised?

Answer: There will be no changes in the provision of health care for our veteran patients. A VA staff physician must still supervise and be responsible for all resident delivered care. However, any documentation requirements driven strictly by the CMS billing standards will no longer apply. All documentation practices at VA facilities will be reviewed against the VHA Resident Supervision policy.

Question 3: What documentation requirements now apply in VA teaching settings?

Answer: VHA Handbook 1400.1, Resident Supervision, is now the primary guidance for the documentation of care in teaching settings. This handbook sets out standards for documentation of resident delivered care that is educationally appropriate but maintains the highest standards for high quality and safe patient care and is available on the VA intranet at http://vaww.va.gov/oaa/.

Question 4: What does this change for attending physicians in the VA system?

Answer: Attending practice will change very little as a result of this decision. A VA staff physician must still supervise and be responsible for all resident delivered care. However, any documentation requirements driven strictly by the CMS billing standards no longer apply. All documentation practices at the facility need to be reviewed against the Office of Academic Affiliations (OAA) Resident Supervision Handbook VHA 1400.1.

Question 5: How does this change relate to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for documentation in the medical record?

Answer: JCAHO standards are hospital accreditation standards and set the absolute minimum requirements for documentation by attending physicians. These requirements include an attending note documented in the medical record within 24 hours of admission, pre-operative notes agreeing with the selection of the procedure, and acknowledgement and agreement with discharge plans. The OAA Residency Supervision handbook in general requires more documentation than JCAHO standards.

Question 6: What about the primary care exception rule?

Answer: The supervision of primary care residents should now be driven by standards of educational quality, patient safety, and effective attending oversight. VA may now bill for all levels of evaluation and management (E&M) services furnished by residents which are supported by proper documentation of care.

Question 7: Will documentation requirements for care delivered by attending physicians alone change as a result of this decision?

Answer: Documentation requirements for care delivered by attending physicians alone should not be affected by this CMS decision.

Question 8: What are the documentation requirements for an inpatient attending physician?

Answer: Current VHA Handbook and JCAHO standards require an admission note within 24 hours, a pre-operative note, and agreement with the discharge or transfer plan.

Question 9: What are the documentation requirements for an outpatient attending physician?

Answer: Each new patient to an outpatient teaching clinic for whom the staff practitioner is responsible, needs to be seen by, or discussed with, the staff practitioner at that initial visit. This must be documented in the chart via a progress note by the staff practitioner or the resident's note which must include the name of the staff practitioner and the nature of the discussion.

Question 10: How will VA handle credentialing requirements?

Answer: VA will accept resident credentialing verification letters (RCVL) from medical schools as sufficient for purposes of meeting credentialing requirements. As needed, medical centers may need to have affiliates provide additional information for claims submission.

Question 11: How will VA handle licensure requirements?

Answer: VA requires residents to obtain licenses only if required by the State in which the VA facility is located; VA does not provide reimbursement to the resident for the cost of the licensure. For CMS purposes, a training or restricted license is sufficient for billing purposes. If a State does not require licensure, individual medical centers need to contact the payer relations department at the insurance company to determine if there is any other specific requirement(s) related to licensure.

Question 12: Can VA now bill for care using resident notes?

Answer: Yes. Resident notes can be used as the documentation for billing third-party insurers.

Question 13: What is the effective date for billing services provided by Residents based on this CMS decision?

Answer: As a result of the CMS decision, VA can bill for Resident services as far back as insurance plan guidelines dictate for the patient's policy.

Question 14: Does VA need to use a modifier when billing for care provided by residents in a properly supervised environment?

Answer: No. VA does not need to use a modifier when billing for this care.

Question 15: Is VA required to use the RES000 UPIN number or VAD000 UPIN number in the absence of a provider identification number when billing third-party insurers?

Answer: In the absence of a provider identification number assigned by the insurance carrier being billed, the VAD000 UPIN number needs to be used in block 82 on a Universal Billing (UB)-92 claim form.

Question 16: Will insurance companies reimburse VA for patient care services provided by residents as a result of this CMS decision?

Answer: VA should be paid for these services according to the insurance policy guidelines and at usual and customary rates for the community. If VA does not receive reimbursement, staff needs to request a formal denial letter from the insurance carrier, and then appeal to the provider relations department along with supporting documentation. If ongoing problems occur with a particular insurer, VA staff need to contact their local District Counsel staff for assistance

Question 17: Can VA use Electronic Claims Processing (i.e., Electronic Data Interchange (EDI)) to bill for care provided by residents in a properly supervised environment?

Answer: Billing for residents electronically is handled the same way as it is on paper. The main EDI issue has to do with the Veterans Health Information Systems and Technology Architecture (VistA) set up for Blue Cross-Blue Shield (BCBS) payers that assign provider identifications

(IDs). Some payers require sites to obtain individual identification numbers for each provider. These sites must contact the payer's Provider Relations Department whenever they add a new provider. The individual provider IDs assigned by the payer must be loaded into VistA. A patch was recently released that allows this data to be uploaded as a batch from a spreadsheet as opposed to individually entered. Including residents in the billing process adds to the workload for these sites, but does not change the basis process.

NOTE: *If sites aren't required to use an individual provider identifier, including residents in the billing process will not impact their VistA EDI set-up. Any questions may be directed to 617-478-3267.*